The Opportunities and Challenges of Health Care Delivery Reform

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Department of Health and Mental Hygiene

Medical Grand Rounds
The Johns Hopkins University School of Medicine
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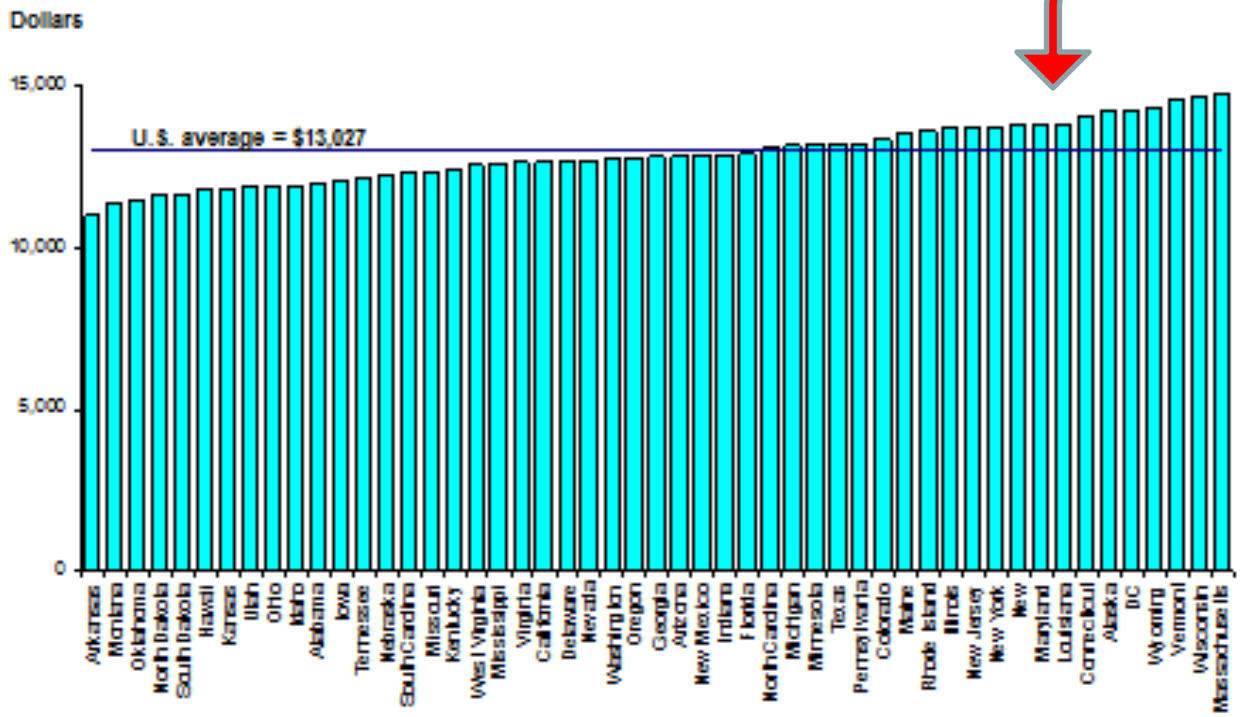
Outline

- Background: Cost and Performance
- The Affordable Care Act
- Health Care Delivery Reform in Maryland
- Opportunities
- Challenges

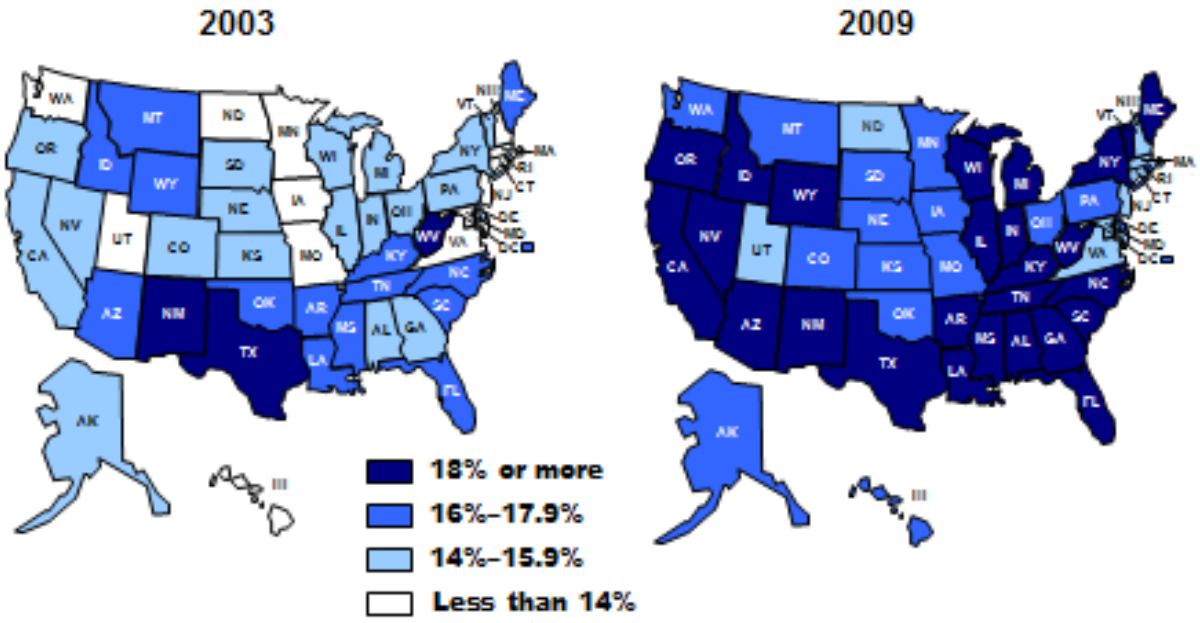
Figure 1. Premiums for Family Coverage, by State, 2009



Data source: 2009 Medical Expenditure Panel Survey–Insurance Component.

Slide from: C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits, The Commonwealth Fund, December 2010.

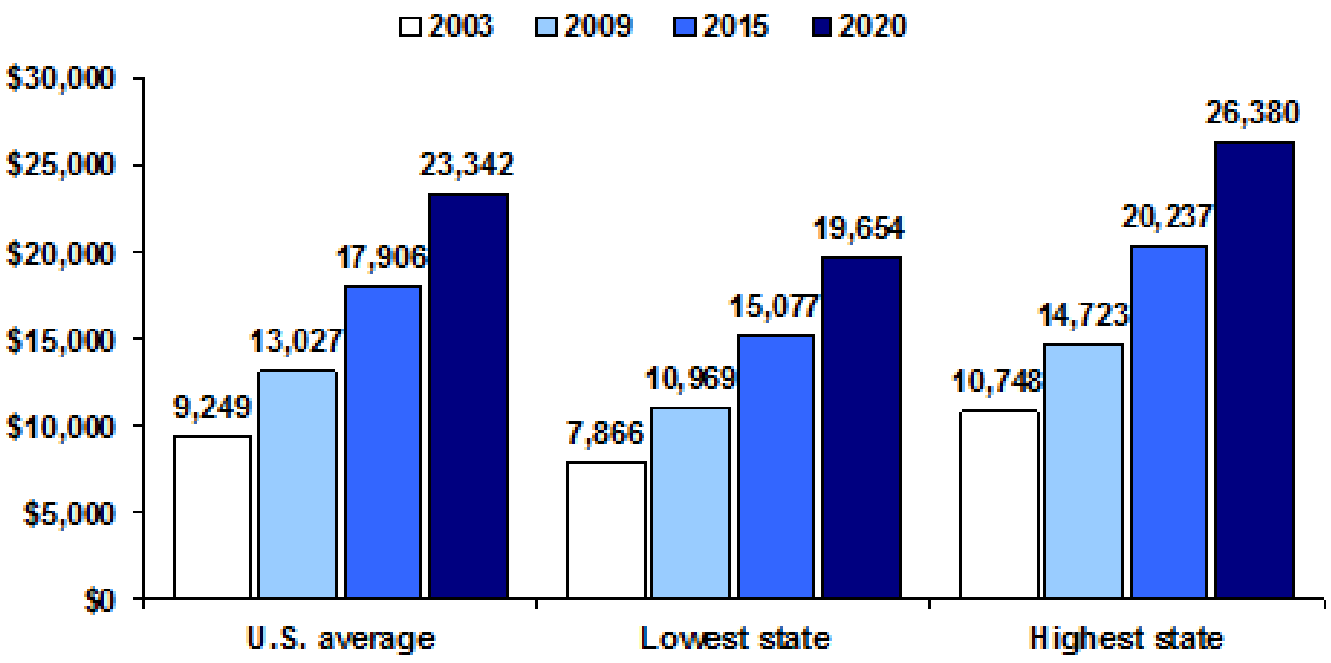
Figure 2. Employer Premiums as Percentage of Median Household Income for Under-65 Population, 2003 and 2009



Data sources: 2003 and 2009 Medical Expenditure Panel Survey–Insurance Component (for total average premiums for employer-based health insurance plans, weighted by single and family household distribution); 2003–04 and 2009–2010 Current Population Surveys (for median household incomes for under-65 population).

Slide from: C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits, The Commonwealth Fund, December 2010.

Figure 4. Premiums for Family Coverage, 2003, 2009, 2015, and 2020



Data sources: Medical Expenditure Panel Survey–Insurance Component (premiums for 2003 and 2009); Premium estimates for 2015 and 2020 using 2003-09 historic average national growth rate.

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Medicaid

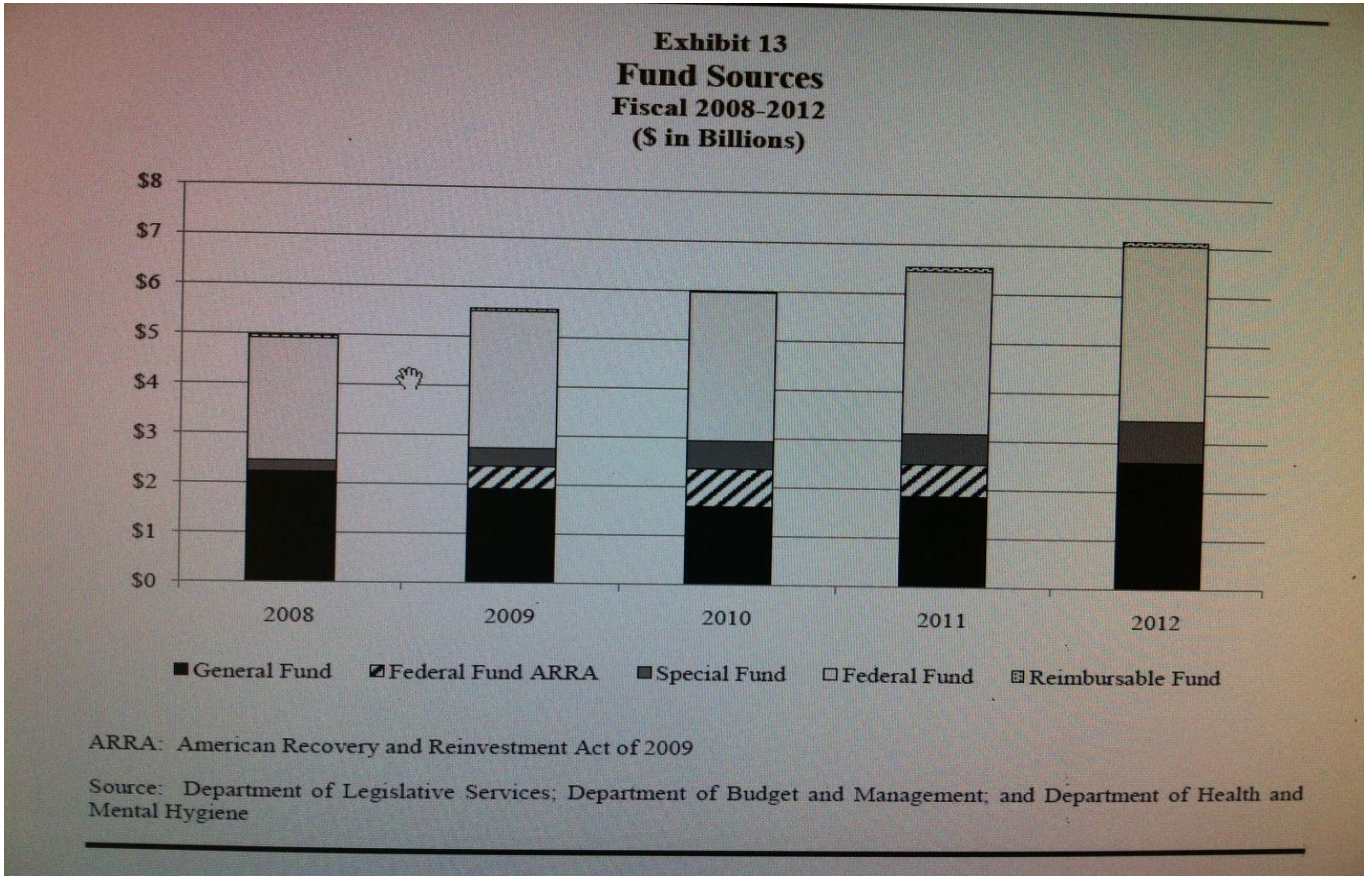
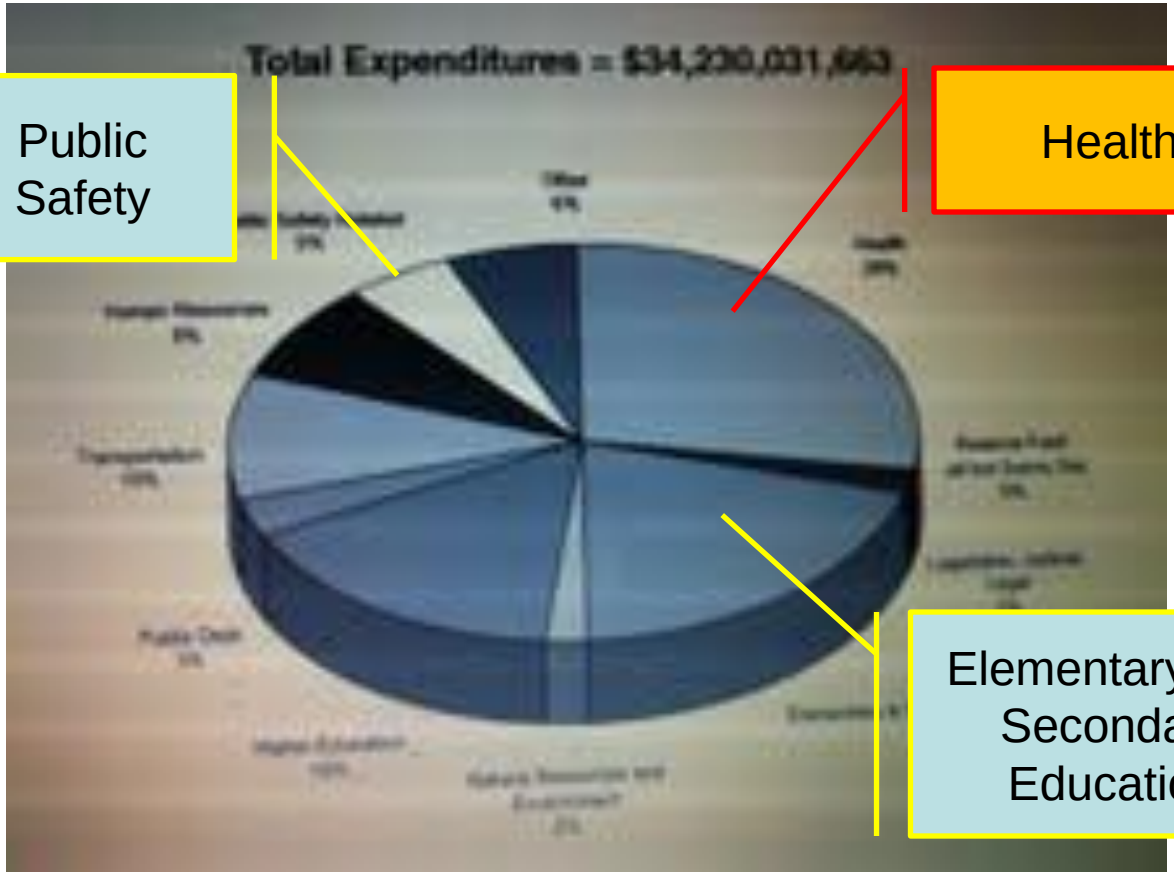


Exhibit 13
Fund Sources
Fiscal 2008-2012
($ in Billions)
$8
$7
$6
$5
$4
$3
$2
$1
$0
2008
2009
2010
2011
2012
General Fund
Federal Fund ARRA
Special Fund
Federal Fund
Reimbursable Fund
ARRA: American Recovery and Reinvestment Act of 2009
Source: Department of Legislative Services; Department of Budget and Management; and Department of Health and Mental Hygiene

FY 2012 Maryland Budget



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REPORT CARD

GRADING PERIOD	1	2	3	4
READING	A			
WRITTEN COMMUNICATION	A			
MATHEMATICS	C			
SCIENCE/HEALTH	B			
SOCIAL STUDIES	B			
ART	A			
MUSIC	A			
PHYSICAL EDUCATION	C			
Grade Average	B			

Attendance:					
	Present	40	____	____	____
	Absent	0	____	____	____
	Tardy	1	____	____	____

A = Excellent • B = Good • C = Satisfactory • N = Needs Improvement
U = Unsatisfactory • I = Insufficient / Incomplete

Student: _____ Grade: _____ Year: _____

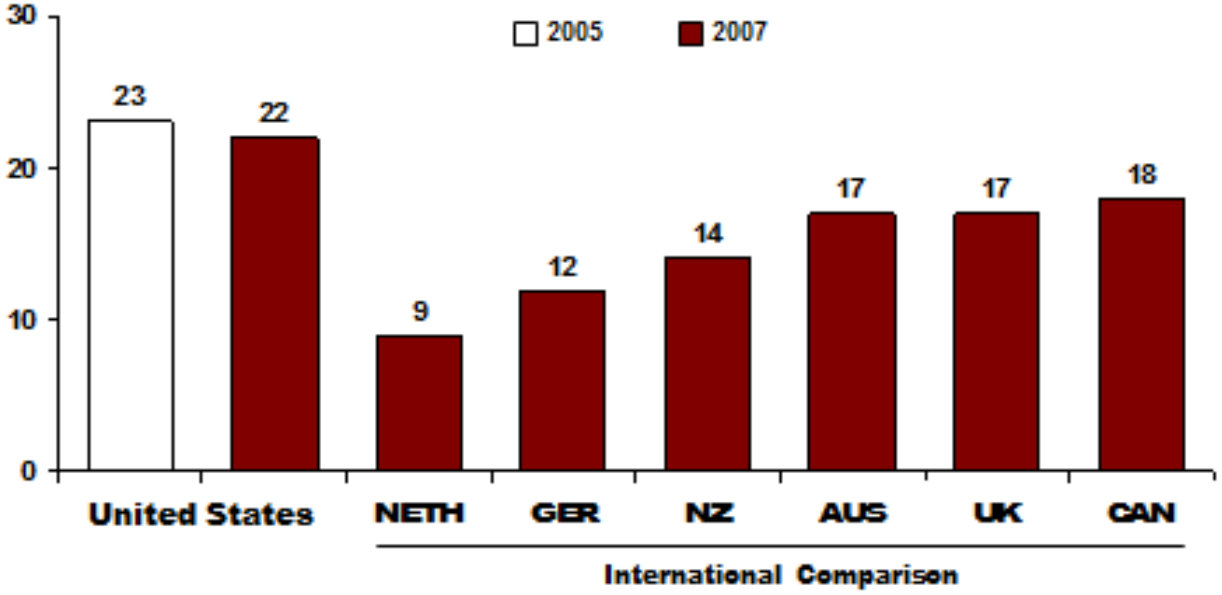
Barriers to Performance

- Weak primary care infrastructure, poorly connected to tertiary care
- Health care system generally pays for volume, not value
- Few incentives for high quality care

EFFICIENCY

Test Results or Medical Records Not Available at Time of Appointment, Among Sicker Adults

Percent reporting test results/records not available at time of appointment in past two years



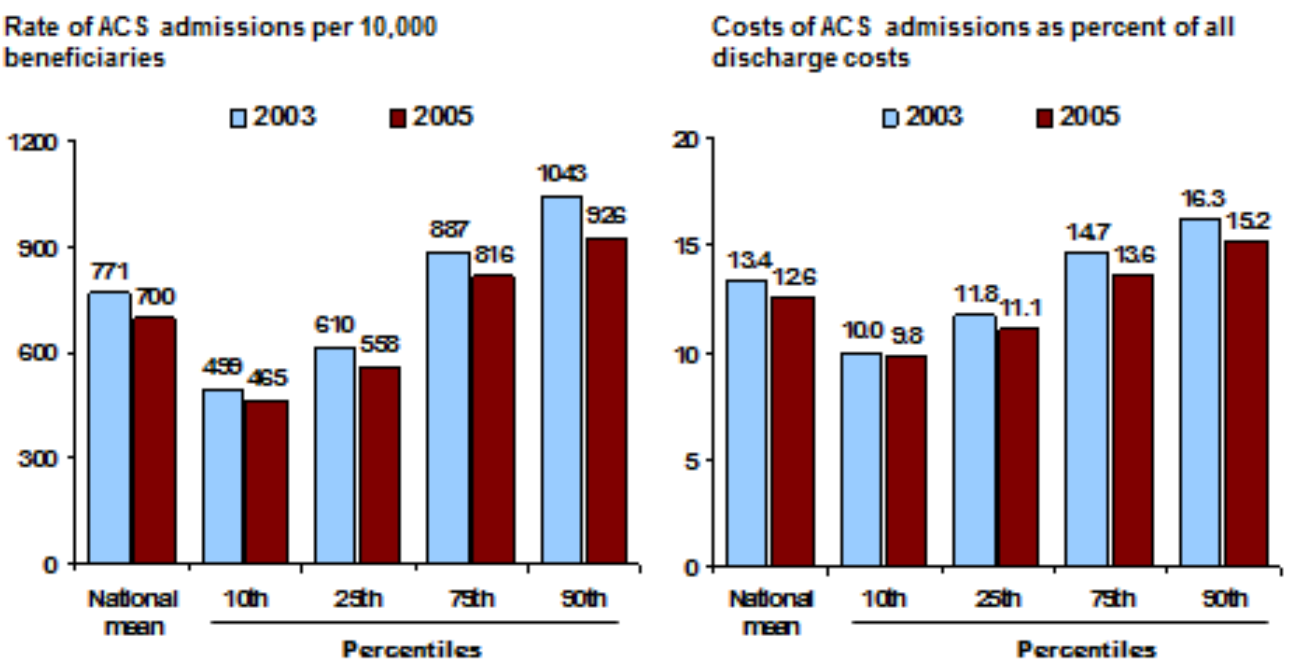
AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008 63

Slide from: The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008, The Commonwealth Fund, July 2008

EFFICIENCY

Medicare Admissions for Ambulatory Care–Sensitive Conditions, Rates and Associated Costs, by Hospital Referral Regions



See report Appendix B for complete list of ambulatory care-sensitive conditions used in the analysis.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008 67

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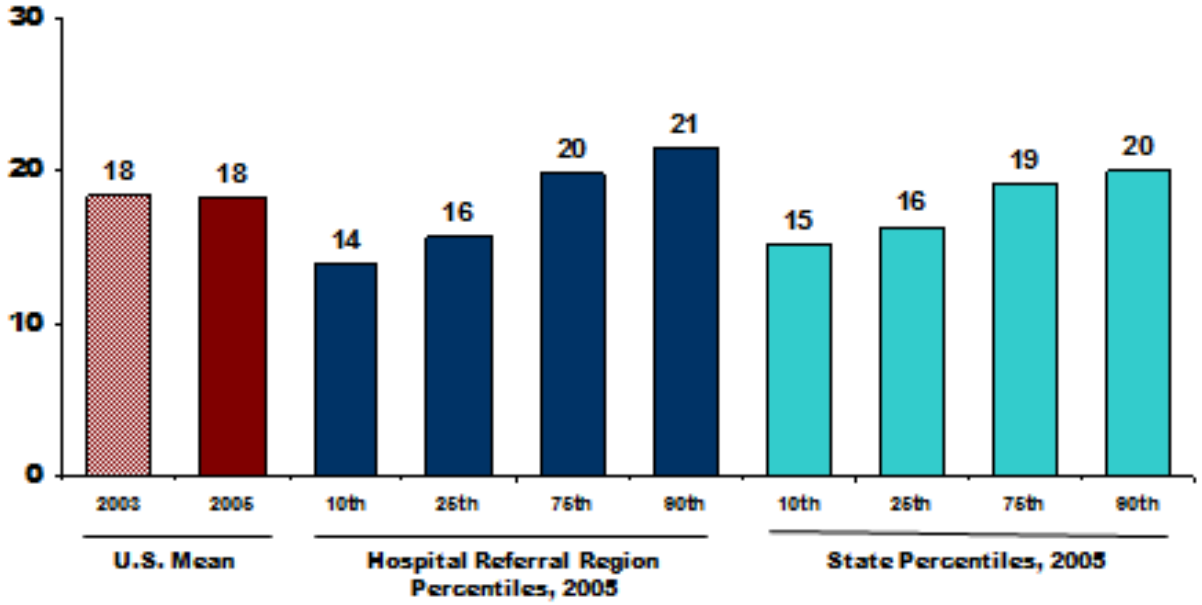
EFFICIENCY

Medicare Hospital 30-Day Readmission Rates

Percent of Medicare beneficiaries admitted for one of 31 select conditions who are readmitted within 30 days following discharge*



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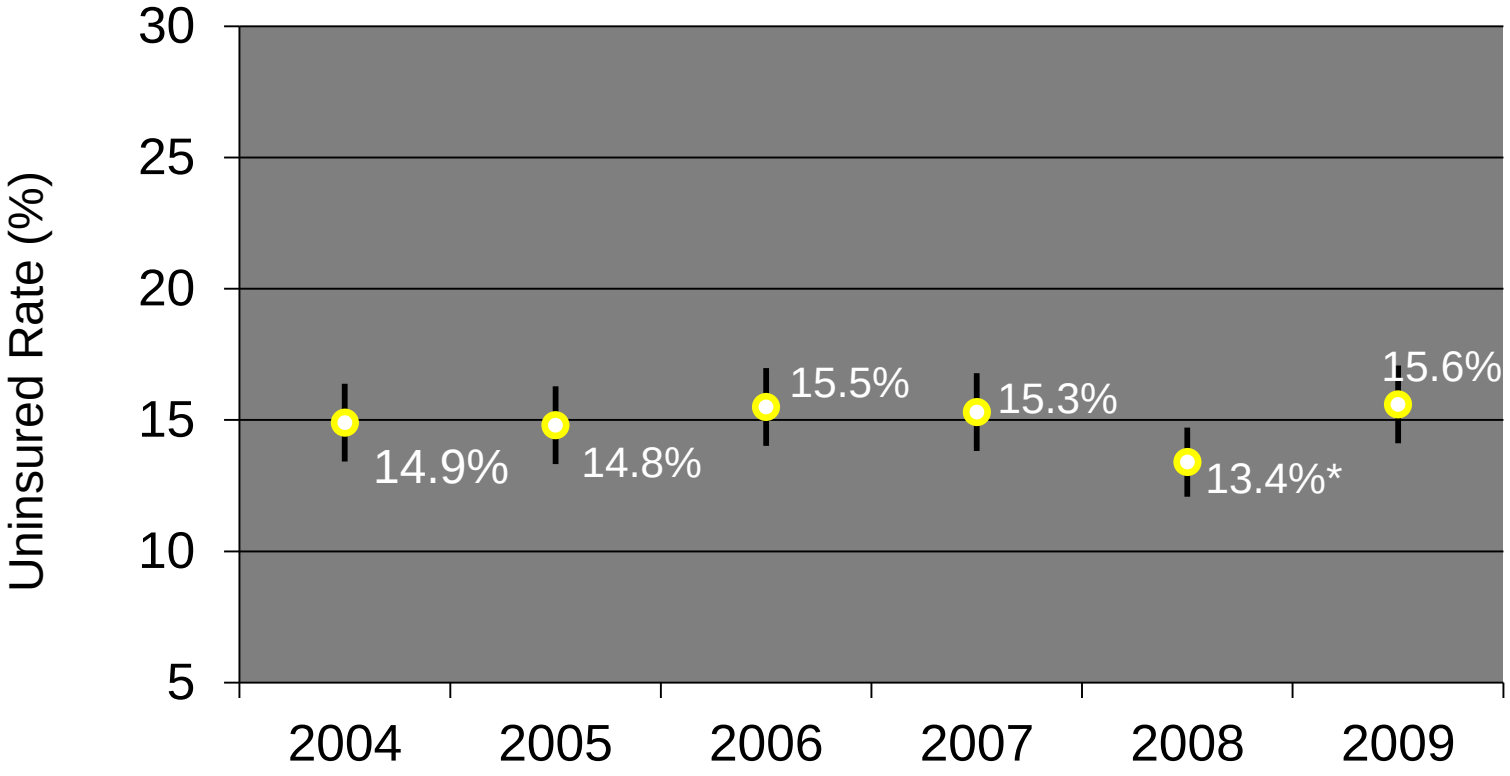
March 23, 2010: The Affordable Care Act

Key Aspects of the ACA

- Strengthen existing insurance coverage
- Expand coverage through health benefit exchanges and public programs
- Provide financial support for access
- Improve cost and quality of care

Trend in Uninsured Rate in Maryland, 2004 through 2009



***** Differs significantly from the 2007 & 2009 estimates using a 90% C.I.

MHCC Analysis of Current Population Survey, Jan. 2011

ACA Coverage Expansions

- Medicaid expansion to 133% poverty
- Health insurance exchanges
  - Subsidies to 400% poverty
  - Small business tax credits

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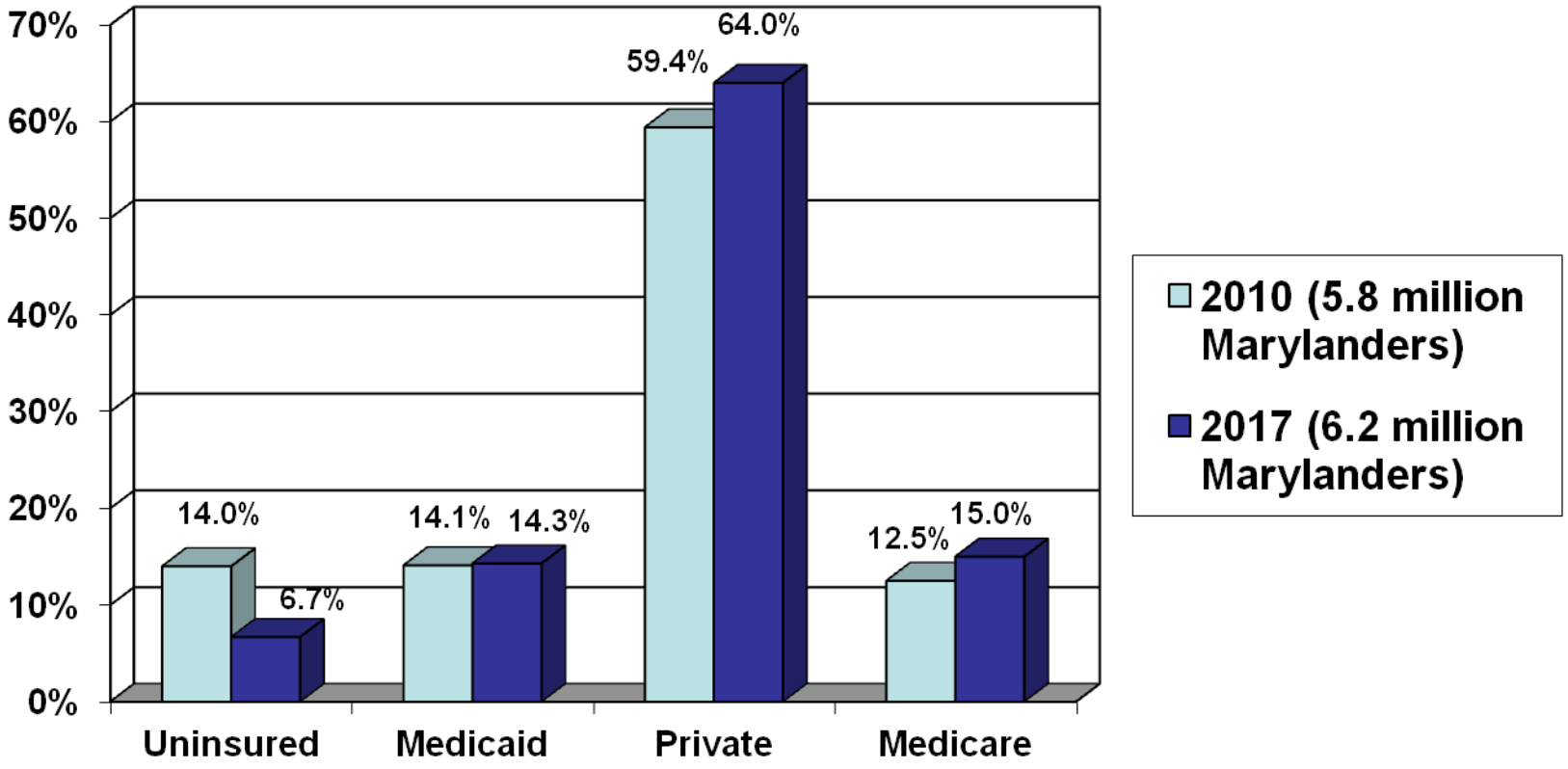
Affordable Care Act Anticipated to Reduce Maryland Uninsured by Half



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Hilltop Analysis (UMBC)

- ACA provides $853 million in savings to state budget by 2020
  - Less uncompensated care, no high risk pool
  - Drug rebates
  - Enhanced federal match
- 350,000 more Marylanders covered
- But…

ACA Support Will Decline

- 100% federal match for expansion population tapers off
- Exchange must become self-sustaining
- Key question: will we have made enough progress reducing costs and improving performance?
- Key answer …


Health
Care
Delivery
Reform

Goal is the “Triple Aim”

1. Improving individual experience of care
2. Reducing per capita health care costs
3. Improving the health of the population

ACA Opportunities (1)

- Patient-centered medical homes
  - 24/7 care management and support
  - Interdisciplinary teams
  - Coordinate care through care planning
  - Collect data on outcomes and cost

ACA Opportunities (2)

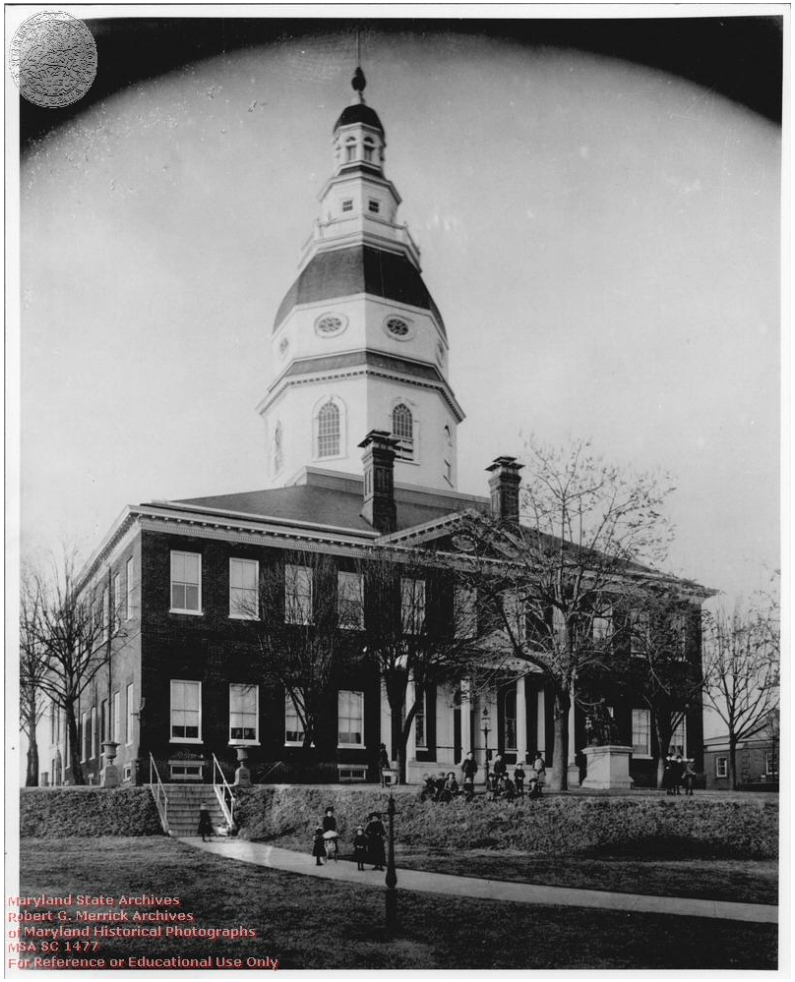
- Accountable Care Organizations
  - Vertically integrated units that share savings with payers
  - Must handle at least 5000 patients and commit for 3 years
  - If meet quality measures, get to share savings below benchmark per capita costs
  - Medicare to certify in 2012

ACA Opportunities (3)

- Pilot programs for bundled payments, readmissions reduction, and reduction in hospital-acquired conditions.
  - Limited to Medicare

As few troops would stand and fight in the face of England's battle-tested professional army, the fact that the Maryland Line functioned and operated as a disciplined unit was not lost on Washington. The Maryland Line's record of service made a lasting impression as Washington remembered the old line in his personal writings…

--Maryland State Archives



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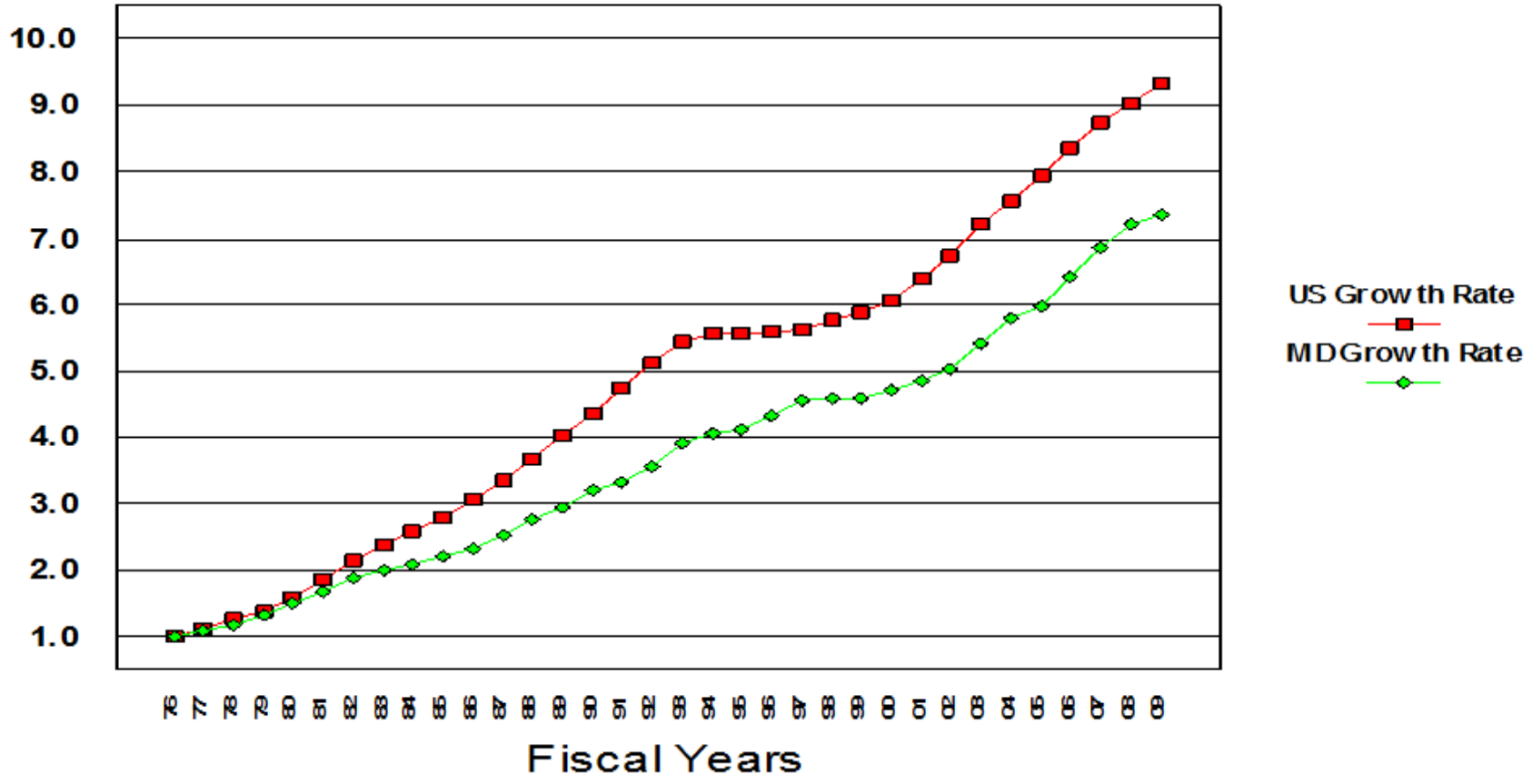
The Only State with All-Payer Rate Setting System

- 47 acute care hospitals
- Each has payment structure set for all payers; no cost shifting
- Good data collected on all admissions
- Shared uncompensated care costs

Indexed Rate of Growth Hospital Cost per Adjusted Admission 1976-2009



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Maryland Efforts

- Quality of care initiatives
- Hospital payment reform
- Patient centered medical home
- Health information technology

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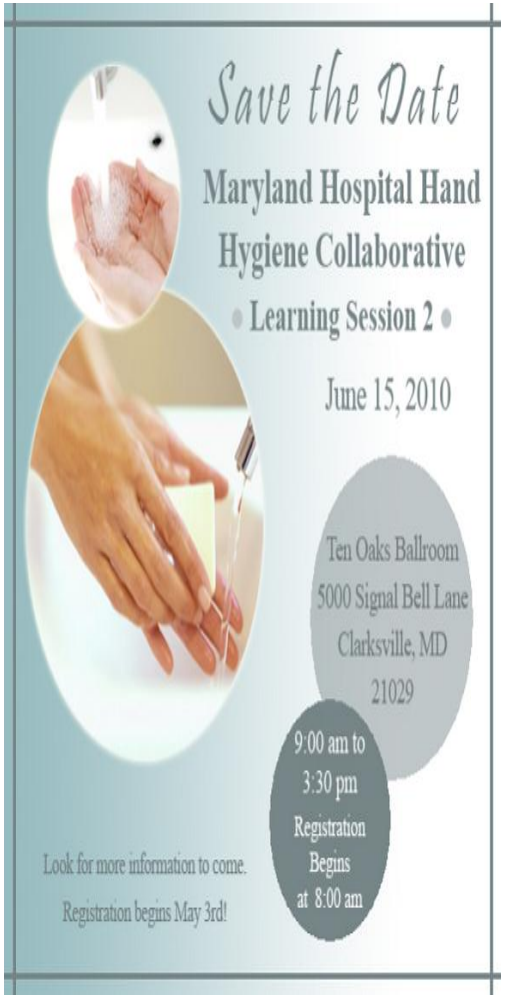
Maryland Health Quality and Cost Council



HEALTHIEST MARYLAND

Where the healthiest choice is easy

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Value Based Purchasing

- Implemented by All-Payer Rate System 2008
- 19 core measures – 4 clinical domains & patient experience of care
- Relative performance linked to rewards/penalties in annual inflation update

Measure	Definition
AMI-1	Aspirin at Arrival
AMI-2	Aspirin prescribed at discharge
AMI-3	Angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) for left ventricular systolic dysfunction (LVSD)
AMI-4	Adult smoking cessation advice/counseling
AMI-5	Beta blocker prescribed at discharge
AMI-6	Beta Blocker at Arrival within 24 hours
HF-1	Discharge instructions
HF-2	Left ventricular systolic function (LVSF) assessment
HF-3	ACEI or ARB for LVSD
HF-4	Adult smoking cessation advice/counseling
PN-2	Pneumococcal vaccination
PN-3a	Blood cultures performed within 24 hours prior to or 24 hours after hospital arrival for patients who were transferred or admitted to the ICU within 24 hours of hospital arrival
PN-3b	Blood culture before first antibiotic – Pneumonia
PN-4	Adult smoking cessation advice/counseling
PN-5c	Antibiotic within 6 hours
PN-7	Influenza vaccination
SCIP-INF-1	Antibiotic given within 1 hour prior to surgical incision
SCIP-INF-2	Antibiotic selection
SCIP-INF-3	Antibiotic discontinuance within appropriate time period postoperatively

Source: HSCRC

Hospital Acquired Conditions

- 49 potentially preventable complications
- $557 million of excess cost in 2010
- Method ranks hospitals on a risk-adjusted rate of 49 complications, weighted by cost factor
- Public reporting

HAC Initiative: Outcomes

- All-Payer System has reallocated $4 million from poor-performers to better performers (relative to state-wide average)
- 12% drop in the number of hospital-acquired complications 2009 to 2010, representing $62.5 million reduction in hospital cost

Source: HSCRC

Maryland Efforts

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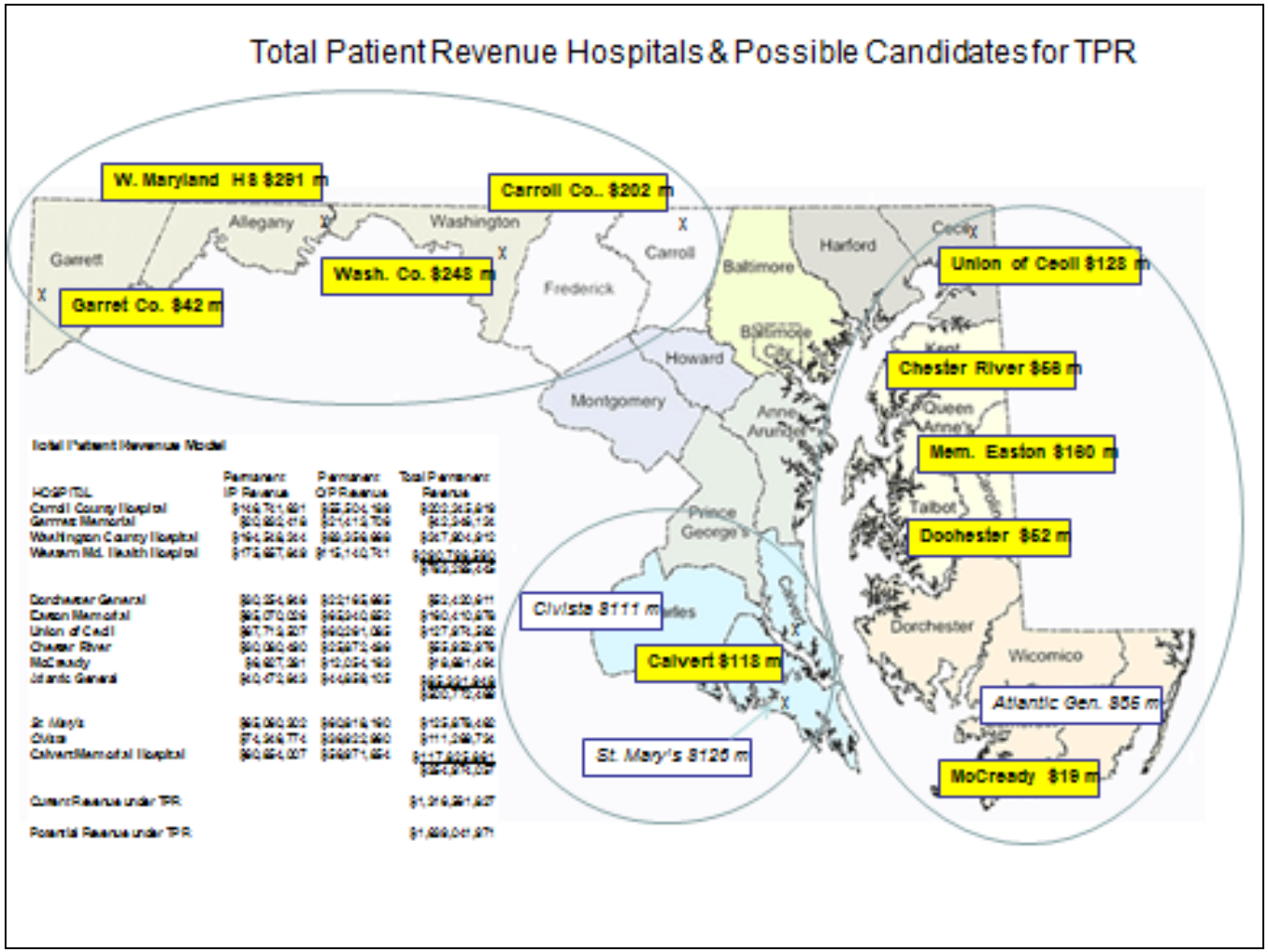
Global Budgets

- Global Budget Model (Total Patient Revenue or TPR) applicable to hospitals with defined catchment areas
- All-payer rate system has established a Global Budget for all inpatient and outpatient hospital services for a facility (100% fixed cost system)
- mechanism to control unnecessary admissions, readmissions and shift care to less expensive outpatient setting
- Coupled with links to quality metrics and monitoring of service use metrics
- Platform for ACO
- [Slide adapted from HSCRC]



Source: HSCRC

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Admission/Readmission

- All-payer rate system currently negotiating with 25 hospitals to establish an 30 day window admission-readmission based constraint
- Hospitals proposing to go at risk for all-cause readmissions relative to a base year (case-mix adjusted) = $1.2 billion/yr
- Actual revenue at risk = 8-9% of total revenue
- If 30-50% reductions possible = savings of between $400 and $600 million per year
- [Adapted from HSCRC slide]

Next Steps: Include Physicians

- Physician/Hospital Case Rates (Surgical Procedures)
- Ability of Hospitals to “Gain Share” with Physicians

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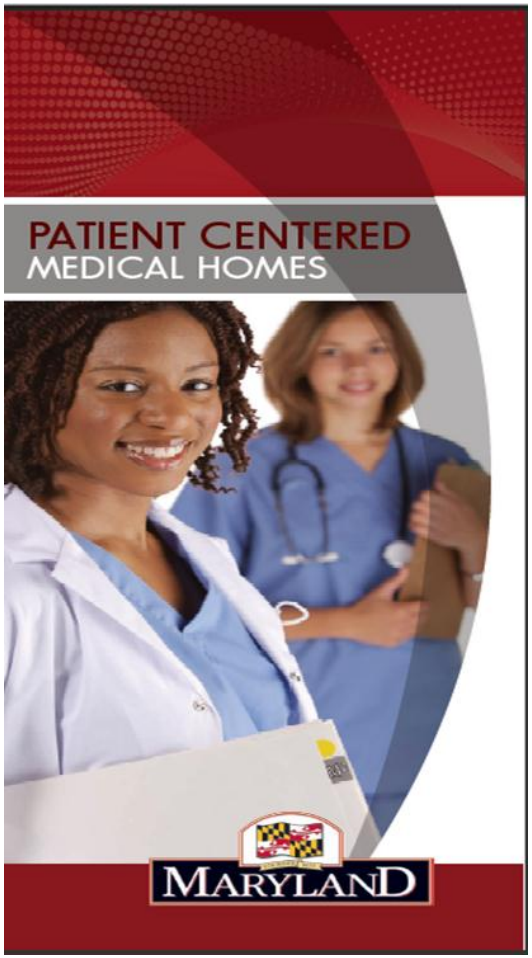

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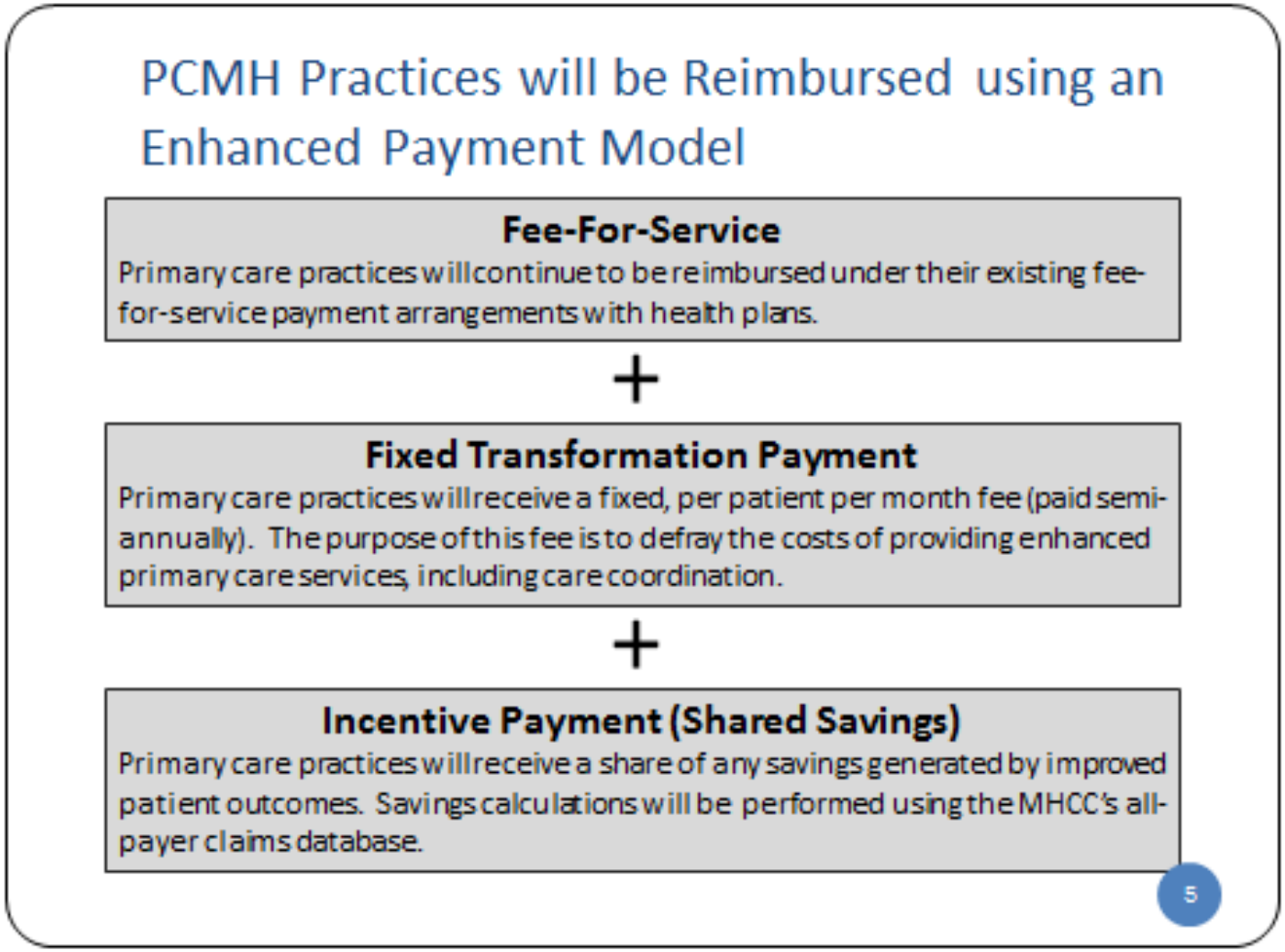
Multi-Payer Model



200K Patients

60 practices

Goal of NCQA Certification

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CareFirst Model

- Involves all CareFirst enrollment of 2,300 participating providers
- CareFirst provides direct nursing support to primary care doctors for care plans
- Model to calculate risk-adjusted cost and savings that blends global capitation and fee-for service
- Practices get higher fees, share of savings

Maryland Efforts

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HIT in Maryland

- CRISP overseeing Health Information exchange
- 400 primary care doctors so far moving to EHR
- All acute care hospitals planning to report to HIE

Opportunities

- ✓ Better align financial and clinical incentives in health care system
- ✓ Improve performance and control cost
- ✓ Make health care costs more manageable for small business and individuals
- ✓ Empower health care institutions and professionals
- ✓ More flexibility for doing what works

Challenges

- Who leads?
- Will ACOs misuse market power?
- Will we adapt our models for hospital capacity?
- What happens to health care providers who have trouble with the transition?

Conclusion

- Very exciting time for American medicine
- The Old Line State is on the cutting edge of delivery system reform
- Given the challenges of cost and performance, we must embrace the triple aim to succeed

Acknowledgments

- HSCRC
- MHCC
- Governor Martin O'Malley
- Lt. Gov Anthony Brown

Additional Notes

- The website of the Department of Health and Mental Hygiene is
- http://www.dhmh.state.md.us
- Follow Dr. Sharfstein on Twitter @drjoshs

- [This slide added after Grand Rounds presentation]